NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

New Hampshire Confidential COVID-19 Case Report Form v 3/28/2020

For Reporting Suspect and Confirmed Cases

☐ New diagnosis

☐ New hospitalization or death of previously confirmed patient

Report Date: ____/____/_____

Only need to complete information in shaded areas.

Patient Information

Name _____
(Last) (First) (M.I.)

Date of Birth ____/____/_____ Age _____ Sex: ☐ Male ☐ Female ☐ Other

Address _____ City/Town _____ State _____ Zip _____

Phone: Cell_____ Home _____ Work _____

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Native Am./Alaskan Nat ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Occupation/Employment _____ Employer: _____

Healthcare Worker: ☐ Yes ☐ No ☐ Unknown Long-term care facility Resident: ☐ Yes ☐ No ☐ Unknown

Symptoms and Clinical Information

Symptom Onset Date: ____/____/_____ ☐ Fever ☐ Cough ☐ Shortness of breath ☐ Sore throat

☐ Head ache ☐ Body aches ☐ Loss of taste/smell ☐ Sinus congestion ☐ Runny nose ☐ Chest tightness

☐ Other: _____

Specimens Collected: ☐ No ☐ Yes Date: ____/____/_____ Laboratory: _____

Where were specimens collected: _____

Was appropriate PPE used for testing: ☐ Yes ☐ No ☐ Unknown

Is the patient hospitalized for their illness? ☐ Yes ☐ No ☐ Unknown

Hospital Location: _____ Dates: ____/____/_____ - ____/____/_____

In ICU? ☐ Yes ☐ No ☐ Unknown Dates: ____/____/_____ - ____/____/_____

Required mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

Did the patient die? ☐ Yes ☐ No ☐ Unknown if yes, date: ____/____/_____ Location: _____

Did the provider indicate that COVID-19 was a contributing cause of death? ☐ Yes ☐ No ☐ Unknown

Risk Factors/Reason for Testing (check all that apply)

International Travel: _____	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Domestic Travel: _____	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Contact to a case: _____	☐ Yes	☐ No	☐ Not asked	☐ Unknown
No known risk factors: _____	☐ Yes	☐ No	☐ Not asked	☐ Unknown

Notes: _____

Health Care Provider Reporting Information

Person Reporting: _____ Provider _____ Phone _____

Provider Facility/Practice Name _____ City/Town_____ State_____

Fax to: (603) 271-0545
Office Phone: 603-271-4496

For NH DHHS Use Only ☐ **Entered in NHEDSS** ☐ **Assigned to Investigator**
☐ **Confirmed** ☐ **Probable** ☐ **Suspect** ☐ **Not a case**